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Director of Insurance

REGULATORY BULLETIN 2006-02¹

TO: Life and Disability Insurers, Health Care Services Organizations, Hospital, Medical, Dental and Optometric Service Corporations, Life and Health Insurance Administrators, Third Party Intermediaries, Professional Associations and Interested Parties

From: Christina Urias
Director of Insurance

Date: January 20, 2006

RE: **Health Care Provider Timely Payment and Grievance Law**

1. Introduction

The "Managed Care Accountability Act" [Laws 2000, Ch. 37 (HB 2600)] establishes requirements for health care insurers ("insurers") to: (1) process and pay health care provider ("provider") claims according to certain standards; (2) establish an internal system for resolving provider grievances; and, (3) report to the Insurance Department on those grievances.²

In 2005, the legislature amended the timely pay and grievance law (ARS §§ 20-3101 and 20-3102) to add definitions and clarify requirements for claims processing, grievance systems and payment adjustments. [Laws 2005, Ch. 68 ([HB 2138)].³

The timely pay and grievance law reflects legislative recognition that both timely, accurate payment to providers and prompt resolution of their grievances are essential components of a functional health care insurance system. A health care services organization (HCSO) that fails to pay providers or resolve their grievances may not have the "appropriate mechanism" required under ARS 20-1054(A)(2). For any insurer, failure to pay providers or properly resolve their grievances may disrupt patient care and provider networks. Moreover, timely payment of claims is an integral indicator of an insurer's fiscal stability.

Circular Letter 2000-15 explained the Department's implementation of the original timely pay law. **This Regulatory Bulletin supersedes Circular Letter 2000-15, which is hereby withdrawn.** This Regulatory Bulletin reviews the Department's implementation of the original law and explains the Department's planned implementation of the amendments. It addresses questions of interpretation

¹ This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties, you may petition the agency under ARS § 41-1033 for a review of the Statement.

² For a summary of this part of HB 2600, please see Circular Letter 2000-6, p. 35

³ For a summary of HB 2138, please see Regulatory Bulletin 2005-4, pp. 2 and 3.

raised since the January 1, 2001 effective date of the original law and revises the list of grievance types subject to reporting, as originally set forth in Circular Letter 2000-15.

2. Clean Claims

By defining “clean claim” in the original timely pay law, the legislature acknowledged that providers have an obligation to submit clean claims if they expect insurers to pay claims on a timely basis. With HB 2138, the legislature revised the definition of “clean claim” to establish that the term “additional information” includes Coordination of Benefits (COB) information. ARS § 20-3101(2). In other words, a claim is not clean if an insurer cannot determine whether to approve or deny it without obtaining (among other things) COB information. An insurer making a reasonable effort to obtain COB information in order to process a claim may pend that claim in order to request the necessary information. See ARS § 20-3102(B) and “Requesting and Handling Additional Information,” below.

3. Claims Processing; Contract Provisions

ARS § 20-3102(A) establishes a bifurcated claims handling process. An insurer has thirty (30) days from receipt of a clean claim to adjudicate the claim and thirty (30) days from the date of adjudication to pay any approved portion of the adjudicated claim. As a result, insurers must be able to identify by date, at least three (3) points in the processing of a claim that is clean when the insurer first receives it: (1) receipt; (2) adjudication; and, (3) payment or denial. Two (2) or more of these points may occur on the same date.

ARS § 20-3102(A) provides that an insurer and a provider may contract for an adjudication period, or payment period, that varies from the statutory requirement of thirty (30) days each. If the provider and insurer contract for non-statutory periods, then the contract governs the length of the periods, but failure to adjudicate or pay within the applicable contractual period is still a violation of Title 20.

The timely pay and grievance law contemplates that an insurer-provider contract can modify some statutory requirements, however, an insurer and a provider may not enter into a contract that negates the effect of ARS § 20-3101 et seq. The Department is aware that some insurers have provider contracts that purport to eliminate the bifurcated receipt-to-adjudication and adjudication-to-payment periods and replace them with a single claims-processing period from receipt to payment. ARS § 20-3102(A) does not permit this arrangement; thus, a provider contract with such a single claims-processing period from receipt to payment violates ARS § 20-3102(A). To illustrate: An insurer may enter into a contract with a provider that allows the insurer fifteen (15) days to adjudicate a clean claim and fifteen (15) days to pay it, if approved. The insurer may not enter into a contract that simply allows the insurer to pay an approved clean claim within thirty (30) days of receiving it.

ARS § 20-3102(A) mandates that, if an insurer fails to timely pay claims, the insurer must pay interest at the legal rate, beginning on the date payment was due. The legal interest rate, as defined in ARS § 44-1201, is ten percent (10%) per annum. The insurer and provider may contract in writing for a different, reasonable rate but, they may not enter into a contract that excuses the insurer from paying any interest at all.

ARS § 20-3102 has no impact on contractual provisions that the statute does not address, such as time periods for the submission of claims, or the submission of additional information.

4. Additional Information

ARS § 20-3102(B) provides, “If the claim is not a clean claim and the [insurer] requires additional information to adjudicate the claim, the [insurer] shall send a written request for additional information...within thirty [30] days after the health insurer receives the claim... The [insurer] shall notify the... [provider] of all the specific reasons for delay in adjudicating the claim. The [insurer] shall

record the date it receives the additional information and shall adjudicate the claim within thirty [30] days after receiving all additional information.”

A. Requesting and Handling Additional Information

An insurer may “pend” or otherwise set aside an unclean claim, but may not deny it before requesting additional information. Compliance with this requirement does not hinge on how an insurer labels the unclean claim. Compliance depends on how the insurer handles the claim, i.e., whether the insurer links the additional information to the original claim and adjudicates the original claim (a compliant process), or whether the insurer fails to link additional information to the original claim and handles the additional information as a new claim (a noncompliant process).

HB 2138 requires that if an insurer requests additional information regarding an unclean claim, the insurer must record the date it receives the additional information. See ARS § 20-3102(B). This amendment will significantly improve the Department’s ability to review and enforce provisions in ARS §§ 20-3102(B), (D) and (E), where compliance hinges on the date an insurer receives additional information.

HB 2138 clarifies that when an insurer receives additional information, it has thirty (30) days to adjudicate the claim and pay any approved portion. This is a single period, not bifurcated in the same manner as the receipt-to-adjudication and adjudication-to-payment periods established under ARS § 20-3102(A). Insurers must be able to identify by date, at least five (5) points in the processing of a claim that is not clean when the insurer receives it: (1) receipt; (2) request for additional information; (3) receipt of additional information; (4) adjudication of the original claim using the additional information; and, (5) payment or denial.

As with the bifurcated periods established under ARS § 20-3102(A), an insurer and a provider are free to contract for a non-statutory single period under ARS § 20-3102(B). They are not free, however, to contractually substitute bifurcated periods for this single period. The legislature created the bifurcated periods only for claims that are clean when the insurer first receives them and created a single period for processing pending claims when additional information arrives.

B. Requesting COB Information

An insurer making a reasonable effort to obtain COB information in order to process a claim may pend a claim in order to request the necessary information. See ARS § 20-3101(2). Indications of a reasonable effort in this context might include, but are not limited to: (1) a documented basis for the insurer’s belief that COB is available or appropriate, such as information on file regarding an enrollee’s alternate coverage; and, (2) a documented effort by the insurer to obtain the COB information promptly.

C. Requesting Medical Information

When a claim is clean except for medical information, the insurer may only request medical information relating to the medical condition at issue. See ARS § 20-3102(D).

D. Requesting Information the Provider Already Has Submitted

An insurer may not require a provider to resubmit information the provider can demonstrate it already has provided to the insurer. See ARS § 20-3102(E). To make compliance and enforcement of this provision feasible, an insurer must establish and advise providers of a written policy describing how providers may document their prior submission of the requested information, without the provider having to resubmit the information as proof of the initial

submission. For example, such a policy might state that the provider may record the submission in a log that the provider keeps as a regular business practice, or the provider may submit proof of electronic filing.

5. Provider Grievances

ARS § 20-3102(F) requires insurers to establish an internal system for resolving payment disputes and other provider grievances.

A. Purpose of Statutory Grievance System Requirements

This requirement is pivotal to the effectiveness of the timely pay and grievance law, especially because the new law “does not require or authorize the [Insurance] Director to adjudicate individual contracts or claims between health care insurers and health care providers.” See ARS § 20-3102(H). Rather, the law places the duty on every insurer to establish an internal system for resolution of provider disputes. The Department’s role is to verify that an insurer’s grievance system is efficacious.

B. Characteristics of a Grievance

HB 2138 defines “grievance” as “any written complaint that is subject to resolution through the insurer’s system that is prescribed in section 20-3102, subsection F and submitted by a provider and received by a health care insurer.” See ARS § 20-3101(4). A grievance is **not** any of the following:

- A provider’s complaint regarding denial of admission to an insurer’s network. See ARS § 20-3101(4)(a).
- A provider’s complaint regarding termination from an insurer’s network. See ARS § 20-3101(4)(b).
- A complaint that is the subject of a health care appeal under ARS § 20-2530 et seq. See ARS § 20-3101(4)(c).

Moreover, the HB 2138 definition of “grievance” is not limited to payment disputes, or to contracted provider grievances. Insurers may have payment disputes with both contracted and non-contracted providers and will need a grievance system that accommodates and reports payment disputes regardless of the contract status of the provider. At the same time, the grievance system must accommodate grievances from both contracted and non-contracted providers about matters other than payment disputes, including, but not limited to systemic or operational problems, quality assurance problems, or network adequacy problems unrelated to the provider’s contract status.

C. Characteristics of an Internal Grievance System

The law reflects the legislature’s intent that an insurer has both the opportunity and the operational ability to promptly correct its own mistakes. The Department recognizes that insurers’ systems may vary, particularly depending on their product structure and networks, however, the Department expects an insurer’s grievance system to be effective and to include the following basic characteristics:⁴

1. The insurer should describe its system in a written set of policies and procedures, readily available to providers on request. An insurer’s grievance policy should specify the minimum information the insurer needs in order to resolve the grievance and the number of days in which the insurer will do so.

⁴ The Department first set forth item nos. 1-4 in Circular Letter 2000-15; item nos. 5-7 provide the Department’s answers to frequently asked questions.

2. Insurers should strive for an administratively simple system that: (a) providers can readily follow; (b) encourages providers to bring legitimate grievances; and, (c) provides for prompt dispute resolution.
3. The insurer representative responsible for resolving the grievance should be someone other than the person who made the initial decision giving rise to the grievance, and should be someone in a different chain of command (i.e. a neutral “third party”).
4. The system should afford the provider a reasonable opportunity to present information related to the dispute, and to communicate with the decision maker, orally or in writing, as appropriate.
5. Insurers may encourage providers to use a particular form for certain grievances, but may not require them to do so. The Department will consider a communication as a grievance, even if its format is informal, or does not specifically use the words, “this is a grievance...”
6. A grievance is not dependent on nomenclature and insurers may use a term other than “grievance” to refer to grievances. Nonetheless, the Department encourages insurers to use the term “grievance,” because, for example, referring to grievances as “appeals” increases the potential for confusion between a health care appeal and a provider grievance, or referring to grievances as “inquiries” may create a misleading impression regarding an insurer’s duties to process such grievances according to law. See Section 5(D) “Grievances Distinguished from Health Care Appeals,” below.
7. An insurer that has a tiered grievance process must record and report grievances to the Department beginning on the lowest tier. For example, an insurer may have a process which labels grievances as “inquiries”. If the provider rejects the outcome of an inquiry, he or she may file an “appeal”. If the provider does not like the outcome of an appeal, he or she may file a “grievance.” Such a tiered system complies with ARS § 20-3102(F) as long as:
 - The process is administratively simple (see Section 5(C), “Characteristics of an Internal Grievance System,” above); and,
 - The insurer records and reports the first tier “inquiry” as a grievance to the Department.

D. Grievances Distinguished from Health Care Appeals

The Department has received many questions about the difference between a health care appeal (HCA) and a provider grievance. The timely pay and grievance provisions set forth in ARS § 20-3101 et seq. neither limit nor expand the HCA process established under ARS § 20-2530 et seq.

The HCA process permits an enrollee to appeal if the insurer, having conducted utilization review, refuses to authorize a service, or pay a claim, because the insurer believes the service is not covered, or is not medically necessary. Providers often assist their patients in pursuing health care appeals and may pursue such appeals on behalf of patients. See ARS § 20-2530(1), which defines “member” to include an enrollee’s treating provider. Providers appropriately acting on behalf of enrollees may bring a health care appeal of a payment denial to the extent allowed under the appeals process. See ARS § 20-2530 et seq.⁵ On the other

⁵ For a HCA, “‘Claim’ does not include claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers.” A.R.S. § 20-2501(A)(3)(a). “‘Denial’ does not include enforcement of a health care insurer’s deductibles or coinsurance requirement or adjustments for a service or coordination of benefits between health care insurers.” A.R.S. § 20-2501(A)(5)(a).

hand, a provider should use an insurer's internal grievance system (established under ARS § 20-3102(F)) to: (1) submit, on his or her own behalf, grievances of the types listed in Attachment A hereto; and, (2) address payment denials relating to coverage, or medical necessity, that may not be subject to the HCA process.

6. Grievance Records

The law requires insurers to maintain records of provider grievances on a grievance-by-grievance basis. See Section 7(B), "Counting and Categorizing," below. The grievance records must include the information listed in ARS § 20-3102(F) and any additional information the Director requires.

A. Statutory Record-Keeping Requirements

1. Name of provider and provider identification number. Note: Recording a provider grievance *under the enrollee's name* is not in compliance with this requirement.
2. Type of grievance. See Attachment A hereto.
3. Date the insurer received the grievance.
4. Date the insurer resolved the grievance.

B. Additional Record-Keeping Information the Director Requires:

1. Any records necessary to support the Semi-Annual Statutory Grievance Report described below.
2. Number of grievances, if any, pre-empted under Center for Medicare and Medicaid Service guidelines for Medicare Advantage coverage determinations. See Section 11(C), "Scope and Application of Timely Pay and Grievance Law; Medicare Advantage Preemption," below.
3. Number of claims adjudicated during the reporting period. An insurer should not record non-clean claims as adjudicated until after the insurer has received additional information and linked the information to the original claim. See Section 4(A), "Requesting and Handling Additional Information," above.

7. Semi-Annual Statutory Grievance Reports

The law requires insurers to file semi-annually with the Department a grievance report that summarizes all grievance records.

A. Purpose of Semi-Annual Statutory Grievance Report

The Semi-Annual Statutory Grievance Report is a critical monitoring tool that provides the Department with important information about the insurer, its network, and its ability to pay claims and provide services to enrollees. It can serve as an indicator of, among other things, solvency problems, network inadequacies and quality assurance deficiencies.

B. Counting and Categorizing Grievances

For reporting as well as record-keeping purposes, an insurer must categorize each grievance it receives into one of eleven grievance types listed on Attachment A hereto. An insurer must separately treat each claim submitted as an individual grievance. For example, if a provider files a written notice that an insurer failed to pay interest on twenty late-paid claims, the insurer must record that filing as twenty grievances, not one grievance.

On the other hand, an insurer need not record more than one grievance per claim. For example, if a provider files a written notice that that an insurer made three errors processing one claim, the insurer need not record each error as a separate grievance, but may record the entire incident as a single grievance, categorized according to the provider's primary concern.

C. Timing and Format of Semi-Annual Statutory Grievance Reports

Semi-Annual Statutory Grievance Reports are due each October 1 for grievances an insurer receives between January 1 and June 30, and each April 1 for grievances an insurer receives between July 1 and December 31. Reports filed on October 1 should include all data available about the resolution of grievances received between January 1 and June 30 and resolved on or before August 31. Reports filed on April 1 should include all data available about resolution of grievances received between July 1 and December 31 and resolved on or before February 28 (or February 29, if applicable). See Attachments A and B hereto for the format and content specifications for the Semi-Annual Statutory Grievance Report.

Notwithstanding the withdrawal of Circular Letter 2000-15, for the Semi-Annual Statutory Grievance Reports due to the Department on April 1, 2006 and October 1, 2006, insurers may continue to use the Circular Letter 2000-15 grievance types and report specifications, or they may use the grievance types and report specifications set forth in this Regulatory Bulletin. Beginning with the Statutory Grievance Report due on April 1, 2007, insurers must use the grievance types and report specifications set forth in this Regulatory Bulletin.

8. The Role of the Department

Providers should file original grievances **with the insurer**, not with the Department, however, the Department also encourages providers to send a copy of each grievance to the Department at:

Life & Health Division – TP&G Program
Arizona Department of Insurance
2910 North 44th Street, Suite 210,
Phoenix, Arizona 85018-7526

Neither providers nor insurers should address any information relating to enrollee health care appeals to the TP&G Program.

The Department monitors the grievance-related correspondence and calls that it receives from providers. Multiple grievances or calls related to a single insurer may indicate the insurer has systemic or other regulatory compliance problems. The Department uses the information in the Semi-Annual Statutory Grievance Reports to determine whether patterns exist that raise regulatory concerns.

If a provider contacts the Department regarding disputes more appropriately resolved through an insurer's statutory grievance process, the Department staff will educate the providers about the law and refer them to the insurer's provider grievance contact person. See Section 14, "Insurer Contact for Provider Grievances; Notice to the Department," below.

The Department has the authority to investigate complaints of alleged Title 20 violations that do not involve the adjudication of a claim, a grievance or a contract dispute. For example, if a provider alleges that an insurer frequently fails to resolve grievances, or fails to provide a copy of its grievance policy on request, the Department may investigate the complaint and will take appropriate measures to enforce Title 20.

The law does not provide any right of appeal *to the Department* for a provider dissatisfied with the results of an insurer's internal grievance system.

9. Payment Adjustments

ARS § 20-3102(l) provides that an insurer or provider shall not adjust or request adjustment of a payment or denial of a claim more than one year after the insurer has paid or denied the claim.

A. Payments of \$0.00

A denial counts as “payment” of \$0.00 for purposes of starting the clock on the adjustment period.

B. Contract Provisions

HB 2138 provides that if the insurer and provider agree by contract on a length of time to adjust or request adjustment of the payment of a claim, the insurer and provider must have equal time to adjust or request adjustment of the payment of the claim. For example, if a provider contract states that the provider has no more than eight months after a payment to make or request an adjustment, it also must limit the insurer to eight months after payment to make or request an adjustment. Notwithstanding this provision, an insurer cannot contract for an unreasonably limited adjustment period.

C. Impact of COB on Adjustment Period

Fraud is the only exception to the adjustment period. Once the adjustment period expires, an insurer may not adjust a payment on subsequent discovery of a possible basis for COB, or that Medicare was the primary payor. The HB 2138 amendment to the definition of “clean claim” underscores this conclusion. See Section 2, “Clean Claims,” above. An insurer expressly may take the time it reasonably needs to obtain COB or primary payor information *before* it adjudicates a claim. Once an insurer pays or denies a claim, neither the insurer, nor the provider, may extend the adjustment period for any reason other than fraud.

D. Interest Obligations After Adjustment

HB 2138 provides that an insurer does not owe interest on an unpaid or underpaid claim as long as the insurer makes the full payment within thirty (30) days of the date of the claim adjustment. For purposes of administering this provision, the Department will assume that the date of the claim adjustment is the date the insurer re-adjudicates the claim following the adjustment request.

HB 2138 also provides that a provider does not owe interest on an overpayment as long as the provider makes the repayment within thirty (30) days of the date of the claim adjustment. This provision does not create an obligation on the part of the provider to pay interest after a recoupment.

10. Change of Filing Locations

In the event an insurer changes the location (address) at which providers must file claims or grievances, HB 2138 provides that, for 90 days after the insurer changes the location, the insurer must consider a claim or grievance delivered to the original location to be “properly received” (ARS § 20-3102(K)(1)) and must provide prompt written notification to the provider of the change of location (ARS § 20-3102(K)(2)).

If a provider sends a claim or grievance to a changed location more than 90 days after the effective date of the change, the insurer may, but is not required to, consider it properly received. Pursuant to HB 2138, an insurer may not reject a claim or grievance that it timely receives at a correct new location solely because the provider first sent it to an address that was no longer correct.

11. Scope and Application of Timely Pay and Grievance Law

A. Types of Insurers

The law contains no exclusions for particular types of insurance claims or particular insurers and applies to all claims and grievances that providers submit to insurers, including:

- Disability (indemnity) insurers doing business in the group or individual markets.
- Service corporations governed by ARS § 20-821 et seq.

- Health care services organizations (HMOs) governed by ARS § 20-1051 et seq.
- Prepaid dental plan organizations governed by ARS § 20-1001 et seq.

The law does not apply to payors that are not health care insurers or to programs where federal law preempts the state timely pay and grievance law, including:

- Self-insured or self-funded employer plans.
- AHCCCS.
- County governments.
- Workers' Compensation.
- Federal Employee Health Benefit Programs.
- Medicare fiscal intermediaries paying Medicare fee-for-service claims.
- Medicare Advantage (certain exceptions described below).

An insurer that provides the Department with claims data or grievance data for any reason should exclude data for payors or programs to which state law does not apply.

B. Types of Providers

HB 2831 clarifies that the timely pay and grievance law applies to claims and grievances from both contracted and non-contracted providers and out-of-state providers who provide covered services to Arizona enrollees.

Note that the timely pay and grievance law does not define the term "health care provider," whereas, the term "health care professional" is defined elsewhere in the statutes to include individuals licensed under ARS Titles 32 or 36. By choosing the broader term "health care provider," as opposed to "health care professional," the legislature allowed for a more expansive interpretation of the timely pay and grievance law to include those persons who provide health or medical services or goods to an insurer's enrollee, including hospitals, health care professionals, durable medical goods suppliers, pharmacies, and ancillary providers.

C. Medicare Advantage Preemption

The Medicare Prescription Drug, Improvement and Modernization Act ("MMA") preempts state standards "other than State licensing laws or State laws relating to plan solvency." See Section 1856(b)(3) of the Social Security Act, as amended by Section 232 of the MMA; 42 CFR § 422.402. Thus, MMA preempts the timely pay provisions for all Medicare claims.

MMA also preempts the grievance provisions for Grievance Type Nos. 1-8, but does not preempt grievance provisions for Grievance Type Nos. 9 & 10. See Attachment A hereto. Grievance Type Nos. 9 and 10 fall under HCSO state licensure laws because they are elements of an "appropriate mechanism to achieve an effective health care plan" which is a licensure requirement under ARS § 20-1054(A)(2). An insurer should exclude data on preempted Medicare grievances in its Semi-Annual Statutory Grievance Reports (see Section 7, above), or in any other grievance data provided to the Department, although an insurer must be prepared to account for any data excluded from its Semi-Annual Statutory Grievance Reports.

12. **Delegation of Functions**

An insurer cannot escape responsibility under ARS § 20-3101 et seq. by delegating authority to a third party. The law applies to the activities of third party intermediaries (TPIs) as defined in ARS § 20-120(K)(7), third party administrators (TPAs) as defined in ARS § 20-485(A)(1) and unregulated third parties that insurers use to perform provider claims or grievance functions. If an insurer contracts with

a TPI, TPA or other third party, the contract must require compliance with ARS § 20-3101 *et seq.* In addition, each insurer is affirmatively responsible for monitoring the performance of its delegates to ensure that the performance complies with the law and the Department will hold each insurer responsible for its delegate's performance in fulfilling the insurer's statutory responsibilities.

13. Conflicts with ARS § 20-462

ARS § 20-462 is an older statute governing timely payment of first party claims that applied to claims of a "provider who has been assigned the right to receive benefits under the contract by the insured." ARS § 20-462(D). It required an insurer to pay interest on first party [clean] claims not paid within thirty (30) days of the insurer's receipt of an acceptable proof of loss (payable from the date the insurer receives the clean claim).

The payment time period and interest accrual period in ARS § 20-462 directly conflict with the provisions of ARS § 20-3102(A). Under the timely pay law, an insurer must approve, but not necessarily pay, a clean claim within thirty (30) days of receipt. The insurer has an additional thirty (30) days after approval to issue payment and interest accrues from the payment due date, rather than from the date the insurer received the clean claim.

The timely pay law governs health care insurer payment to health care providers more specifically than did ARS § 20-462. Therefore, as stated in Circular Letter 2000-15, the timely pay law superseded ARS § 20-462 as it previously applied to the timing of payments to health care providers, and any implementing rule such as A.A.C. R20-6-801, and substantive policy statements such as Circular Letter 93-1. Webb v. Dixon, 104 Ariz. 473, 475-76, 455 P.2d 447, 449-50 (1969); Alexander v. Fund Manager, Public Safety Personnel Retirement System, 166 Ariz. 589, 593, 804 P.2d 122, 126 (Ct. App. 1990); McLeod v Chilton, 132 Ariz. 9, 16, 643 P.2d 712, 719 (Ct. App. 1981).

This Regulatory Bulletin reaffirms that:

- The Director expressly withdrew Circular Letter 93-1 on November 9, 2000.
- The Unfair Claims Settlement Practices Act (ARS § 20-462) and any implementing rules continue to apply to treatment of claims for reimbursement to enrollees who have paid providers directly for covered out-of-network services.

14. Insurer Contact for Provider Grievances; Notice to the Department

No later than Wednesday, February 15, 2006, each health care insurer must designate one person as the primary contact for all questions (from providers and the Department) relating to provider grievances and submit to the Department the individual's name, title, address, telephone number, fax number and e-mail address. No later than Wednesday, February 15, 2006, each insurer shall also provide the Department with a complete list of the locations or addresses to which, as of that date, it directs providers to send their grievances.

Insurers should submit this information by e-mail to:

providerinfo@id.state.az.us

or by hard copy to:

Life and Health Division – TP&G Program
Arizona Insurance Department
2910 North 44th Street, Suite 210,
Phoenix, Arizona 85018-7526.

An insurer should not submit any contact information relating to enrollee health care appeals to the TP&G Program.

An insurer shall notify the Department in writing (and in advance if practical), of any change in the primary contact person for provider grievances.

When a provider erroneously contacts the Department regarding a matter appropriate for resolution through the insurer's grievance process, the Department will advise the provider to: (1) submit the grievance in writing to the appropriate location; and, (2) if necessary, to contact the insurer's provider grievance primary contact person for help.

15. Effective Date

The amendments to ARS §§ 20-3101 and 20-3102(A)-(E) apply to claims for dates of service on, or after, January 1, 2006.

The amendments to ARS § 20-3102(F) apply to grievances that an insurer receives on, or after, January 1, 2006, and are subject to the grievance reporting timelines described in Section 7(C), "Timing and Format of Semi-Annual Statutory Grievance Reports," above and Attachments A and B hereto.

The amendments to ARS § 20-3102(I) apply to payments or denials that an insurer makes on or after January 1, 2006.

ARS § 20-3102(K) applies to claims or grievances that an insurer receives on or after January 1, 2006.

Any person who has questions regarding this Regulatory Bulletin may contact Audrey Franklin, Timely Pay & Grievance Analyst, at 602-364-2394 or afranklin@id.state.az.us or providerinfo@id.state.az.us.

ATTACHMENT A
 SEMI-ANNUAL STATUTORY GRIEVANCE REPORTS
 GRIEVANCE TYPE AND CONTENT SPECIFICATIONS

Health care insurers must categorize and report each grievance as one of the following Grievance Types:

Grievance Type No.	Description/Basis for Dispute
1	Whether the claim was clean.
2	Failure to timely pay claim.
3	Amount paid (bundling software).
4	Amount paid (other than bundling software).
5	Amount or timeliness of interest payment.
6	Coverage under enrollee's policy (e.g. benefit exclusion, medical necessity, etc.).
7	Pre-authorization/pre-certification/notification.
8	Adjustment request.
9	Network adequacy (other than the provider's contract status).
10	Systemic or operational problems.
11	Other.

A health care insurer should not use Grievance Type 11 ("Other") for more than five percent (5%) of the total number of grievances it reports. On the Department's request, each health care insurer must be prepared to provide the Department with a summary of the grievances the insurer categorizes as "Other".

The list above eliminates certain grievance types listed in Circular Letter 2000-15. Health care insurers should record and report eliminated grievance types as follows:

Old Type	Description	New Type	Description
5	Patient not eligible	6	Enrollee's policy.
6	Service not medically necessary	6	Enrollee's policy.
8	Action inconsistent w/ prior auth	7	Pre-authorization/precertification
9	Whether the provider timely filed the claim.	10	Systemic or operational problems
12	COB – no primary liability	6	Enrollee's policy.
13	Grievance resolved but not paid.	10	Systemic or operational problems
15	Retaliation for patient advocacy	11	Other.
16	Dispute over patient load	11	Other.
17	Quality assurance	10	Systemic or operational problems
19	Dispute over provider contract terms (bundling software)	3	Amount paid (bundling software).
19	Dispute over provider contract terms (other than bundling software)	10	Systemic or operational problems
20	Resolution not implemented	10	Systemic or operational problems
21	Other (non-contractual)	11	Other

ATTACHMENT B
SEMI-ANNUAL STATUTORY GRIEVANCE REPORTS
FORMAT AND SUBMISSION SPECIFICATIONS

Insurers should e-mail their semi-annual grievance reports to providerinfo@id.state.az.us. Each report should be in comma delimited format (AKA Comma Separated Values "CSV"). Cover letters should be in MS Word or sent as free text in the e-mail.

Grievance Statistics File

Each line of the Grievance Statistics File will include the summary information for a specified provider zip code and grievance type and contain the following data:

- Insurer NAIC #.
- Reporting Year.
- Reporting Period (1=Jan to June; 2=July to December).
- Provider Zip Code summarized on that line
- Grievance Type (1-11)
- Total number received.
- Total number resolved: Insurer upheld its position.
- Total number resolved: Insurer reversed its position.
- Total number resolved: Insurer modified position.
- Total number resolved: Other.
- Average number of days to resolve.

Insurers are no longer required to report any amounts in dispute.

For each grievance type, the number of grievances resolved as "Other" should be no more than five percent (5%) of the total number of resolutions for that grievance type. On the Department's request, each insurer must be prepared to provide the Department with a summary of resolutions the categorized as "Other".

If an insurer does not receive any grievances in a reporting period, the insurer must notify the Department of that fact at providerinfo@id.state.az.us by the due date the report for that grievance reporting period. The insurer need not submit a grievance data sheet that shows "0" in every grievance type.

Each insurer should name the Grievance Statistics File in the following fashion: G#####.CSV, where "#####" = insurer NAIC number. For example, the file for an insurer with NAIC number 12345 would be G12345.CSV.

Health Care Provider and Claims File

The Health Care Provider Grievance File should contain one line of data, containing four numbers. The first three numbers should be the number of grievances the insurer received during the reporting period, broken into three categories:

- Total number of Grievances: Category - Professional
- Total number of Grievances: Category - Facility
- Total number of Grievances: Category - Ancillary

The fourth number should be the number of claims the insurer adjudicated during the reporting period. See Section 3(B)(2) of this Regulatory Bulletin.

Each insurer should name the Health Care Provider and Claims File in the following fashion: H#####.CSV, where "#####" = insurer NAIC number. For example, the file for an insurer with NAIC number 12345 would be H12345.CSV.